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# Massachusetts Health Care Cost Trends

## Final Report

August 2012

DIVISION OF
Health Care
Finance and Policy

# Contents



# Executive Summary

Pursuant to the provisions of M.G.L. c. 118G, § 6 1/2, the Massachusetts Division of Health Care Finance and Policy (DHCFP) is required to conduct an annual study of health care cost trends in the Commonwealth, and the factors that contribute to cost growth. In May and June of 2011, DHCFP released three preliminary reports on various facets of health care spending in Massachusetts and held four days of hearings in late June on health care cost growth as part of its second annual responsibilities under Chapter 305 of the Acts of 2008. This final report summarizes the key findings in the preliminary reports released by DHCFP and the Office of the Attorney General (OAG), presents major findings and information generated through the written and oral testimony submitted during public hearings held in June, and outlines recommendations for slowing the annual growth in health care costs.

Massachusetts's landmark health reform law (Chapter 58 of the Acts of 2006, *An Act Providing Access to Affordable, Quality, Accountable Health Care*) established a model for the nation by creating a path to near universal health insurance coverage of its residents. Chapter 58 was designed to expand coverage to health insurance, with over 98 percent of the state's residents now insured. However, the continued rise in health care spending is causing significant challenges in Massachusetts and will continue to do so until it is effectively addressed by policy makers and health care industry leaders. The findings from DHCFP's preliminary reports and other relevant analyses, the investigation by the Office of the Attorney General, and the testimony prior to and during the public hearings identified many opportunities to reform the health care system and increase both the efficiency and quality of care delivered in the Commonwealth. In particular, there was broad consensus on the following key opportunities for developing policy solutions:

- Health care spending continues to grow at an unsustainable rate, as a result of provider price increases and inefficient care evidenced by rates of preventable hospitalizations and avoidable (emergency department) ED visits.
- Variation in provider prices for common services is broad. To the extent that factors such as market position and brand name give high-priced providers an unfair advantage, this variation may represent a significant market dysfunction.
- Fee-for-service reimbursement, which is the dominant form of provider payment in the Commonwealth, perpetuates an inefficient and fragmented health care system, and penalizes providers that seek to improve coordination of care for their patients and to eliminate waste in their practices.
- Providers are largely fragmented, making coordination of care difficult, which in turn promotes inefficiency in the health care system. Increased opportunities for provider integration with a focus on primary care must be facilitated throughout the Commonwealth.
- The current health care infrastructure is ill-equipped to support the provision of coordinated care in Massachusetts. Investments in information technology, workforce development, primary care, and public health and wellness are necessary to improve the efficiency and quality of health care.
- Many currently available insurance products do not present consumers with incentives that will yield efficient, high-quality health care.

The hearings emphasized not only the importance of each of these areas for improvement, but the extent to which they are interrelated. There is broad consensus that these issues cannot be resolved individually, but must be addressed in the context of comprehensive, system-wide reform. To that end, this report outlines DHCFP's policy recommendations to address the rising cost of health care. The following recommendations are supported by the findings and by testimony given as part of the cost trends hearing process. Further details on each recommendation can be found in the body of the report in Section VII, "Recommendations for Health Care Cost Containment in Massachusetts," along with supporting written and oral testimony for each recommendation. A complete summary of hearing testimony can be found in Section VI, "Summary of Public Hearings on Health Care Cost Trends."

1. **Increase coordination of care by aligning health care payments with value.**
   DHCFP recommends that provider payment systems be reformed to remove the inflationary incentives inherent in the fee-for-service system, reward integrated care delivery, and mitigate cost growth over time by reducing expenditures on unnecessary and avoidable care. DHCFP supports the promotion of alternative payment methodologies such as global payments, shared savings arrangements, bundled payments, and episode-based payments. Additionally, any future comprehensive payment reform should be executed in such a way that current inequities in reimbursement are not "baked into" the formulae, given broad consensus that existing price variation may reflect a significant market dysfunction that has yet to correct itself.

2. **Promote the integration of providers to deliver coordinated, comprehensive care.**
   DHCFP recommends that integrated care organizations be developed to foster enhanced coordination of care. A common framework of functions that an integrated care organization will perform should be established by state government, to ensure that health system reform will improve the capacity of providers to advance more efficient care processes.

3. **Ensure that government oversight of the transition to payment reform and system redesign is coordinated and tracks appropriate outcomes.**
   DHCFP recommends that a government body have the authority to "develop appropriate regulations, solvency standards, and oversight for providers who contract to manage the risk of insured and self-insured populations," as recommended by the OAG in its preliminary report. As the Commonwealth works to mitigate health care cost growth and restructure its delivery system, DHCFP recommends that an entity be designated to guide its decision-making and implementation strategy.

4. **Encourage the use of the most appropriate settings for care.**
   Levels of inefficient care such as preventable hospitalizations and avoidable ED visits indicate areas where appropriate use of ambulatory care could prevent or preclude the need for more expensive acute care. DHCFP recommends the increased delivery of primary care and strengthening of care coordination efforts in the Commonwealth. In addition, DHCFP recommends further development and study of select or tiered network products to incent consumers to switch to high-quality, low-cost providers, given increased interest in these products by employers and the potential to lower premiums through their use.

5. **Promote the transparency of health care price and quality information.**
   The continued development of cost and quality metrics is key to ensuring that purchasers have the tools they need to make informed decisions about where to obtain high-quality, cost-effective health care. Although transparency alone will not slow the growth of health care costs, public efforts to monitor and report on provider prices will assist stakeholders in addressing key policy decisions in health system reform.

6. **Develop public databases that enable analysis of health care spending, utilization patterns, and provider quality while promoting administrative simplification.**
   In order to monitor cost trends, highlight areas of opportunity, and spot potential obstacles to health system reform, system-wide data on health care cost and utilization patterns are critical. DHCFP will facilitate availability of the All Payer Claims Database (APCD) as well as provide data about the delivery system's capacity and resources in advance of the issues and opportunities that could potentially arise.

7. **Government should support health system redesign through a variety of efforts.**
   Although comprehensive system reform will require an ongoing cooperative partnership between the public sector and the health care industry, government interventions are necessary to guide and support the marketplace in finding equitable solutions to current imbalances. Potential efforts include providing guidance in developing actuarial tools for new shared-risk insurance products, strengthening health resource planning and the Determination of Need process, and standardizing base rates of provider payments for services.

8. **Invest in infrastructure improvements for the health care system.**
   Substantial investments in infrastructure will be necessary to transition towards an integrated and efficient health care delivery system. Specifically, workforce development opportunities and information technology should be expanded, along with the capacity of provider and payer organizations to utilize the data made available by expanded HIT.

9. **Invest in public health and wellness.**
   Prevalent and costly health care problems such as obesity, diabetes, and asthma indicate the need for improvement not only in the health care delivery system, but in public health and wellness. DHCFP recommends that the Commonwealth continue to promote and invest resources in wellness through public-private partnerships that reduce the incidence and prevalence of common chronic conditions.

10. **Develop and standardize measures of provider quality and health system performance.**
    Providers have adapted to score well on existing quality measures, with little variation in areas of clinical performance for which quality measures are available. New measures should be developed to promote continued improvement of the health care system and to track accomplishment of system redesign goals. Quality measures should be standardized across payers so that providers can focus their efforts on a single set of measures rather than adhering to different measures for different groups of patients.

Many of these recommendations are related, and a piecemeal approach to their implementation would likely limit their impact. The potential for the Commonwealth to lower health care costs and improve quality depends on the success of comprehensive efforts to reform payment mechanisms and the delivery of care.

# Introduction

Pursuant to the provisions of M.G.L. c. 118G, § 6 1/2, the Massachusetts Division of Health Care Finance and Policy (DHCFP) is required to conduct an annual study of health care cost trends in the Commonwealth, and the factors that contribute to cost growth. In May and June of 2011, DHCFP released three preliminary reports on various facets of health care spending in Massachusetts and held four days of hearings in late June on health care cost growth as part of its second annual responsibilities under Chapter 305 of the Acts of 2008 - *An Act to Promote Cost Containment, Transparency, and Efficiency in the Delivery of Quality Health Care*. This final report summarizes the key findings in the preliminary reports released by DHFCP and the Office of the Attorney General (OAG), presents major findings and information generated through the written and oral testimony submitted during public hearings held in June, and outlines recommendations for slowing the annual growth in health care costs.

# Background

Rising health care costs is a pressing national problem, both in the private commercial insurance sector, as well as for public programs like Medicaid and Medicare. It is a more serious issue in the Commonwealth since Massachusetts leads the nation in health care spending. In the past two decades, the percent of family income dedicated to health insurance has more than doubled from 7 percent of the nation's median family income in 1987 to 17 percent in 2006.[1] Such a trajectory of rapid growth in spending, coupled with stagnant wages and slow economic growth, will lead to ever-more significant challenges to both household financial stability and the nation's economy at large. Massachusetts's landmark health reform law (Chapter 58 of the Acts of 2006, *An Act Providing Access to Affordable, Quality, Accountable Health Care* (Chapter 58)) established a model for the nation by creating a path to near universal health insurance coverage of its residents. Chapter 58 was designed to expand coverage to health insurance, and now over 98 percent of the state's residents are insured. Despite this enormous success, Chapter 58 was not designed to address health care costs or spending, and their continued escalation is causing significant challenges in Massachusetts and will continue to do so until they are effectively addressed by policy makers and health care industry leaders. Massachusetts's individuals, families, and employers, as well as state and local government, all continue to struggle to manage the rapidly rising costs of health care, which may pose threats to consumer access to care, stymie wage growth, discourage job creation, and divert potential spending in other sectors of the economy.

1 Testimony during 2010 Cost Trends Hearings from Len Nichols, Director for the Center for Health Policy Research and Ethics, College of Health and Human Services, George Mason University, March 16th, 2010.

# Key Findings from DHCFP Preliminary Reports

DHCFP conducted comprehensive analyses of health care cost trends data to help identify factors which may be contributing to the unsustainable growth in health care costs in Massachusetts. These reports focused on health insurance premiums, price variation, and total spending in the Massachusetts health care marketplace, respectively. A summary of the key findings is presented below. For more detail, please see the full reports (links to which are included in Appendix A).

## A. Massachusetts Private Insurance Premium Trends

### Premium Growth

- From 2007 to 2009, private group health insurance premiums in Massachusetts increased roughly 5 to 10 percent annually, when adjusted for benefits. This compares to consumer price index (CPI-U) increases (for all goods and services) averaging 1.7 percent annually over the same time period nationwide and 2.0 percent in the Northeast.
- Smaller groups paid higher premiums from 2007 to 2009 than mid-size and large groups, when adjusted for demographics, geographic area, and benefits. It is important to note that premium increases for specific employers vary significantly from the average.
- In 2009, small groups had the greatest variation in rate increases of any other group sector, reflecting greater premium volatility in this market sector.
- On average, the level of benefits covered by private group health insurance has declined and member cost-sharing has increased.
- Deductibles and copayments generally increased from 2007 to 2009. For example, in the small group sector, the inpatient copayment in the most popular HMO plan increased from $500 to $1,000.
- Among small groups, average benefits decreased 3.6 percent from 2007 to 2008 and 6.6 percent from 2008 to 2009.
- Enrollment in the lowest-cost HMO plan and the lowest-cost PPO plan was uniformly low across market sectors of all sizes. From 2007 to 2009, enrollment in the lowest-cost HMO and PPO plans combined increased to just two percent in the merged market, and one percent in the mid-size and large group market sectors.

## Medical Loss Ratios

- From 2007 to 2009, the medical loss ratio calculated across all insured market sectors increased from 88 percent to 91 percent.
- Small groups paid a larger per member per month (pmpm) amount towards funds not applied directly to medical expenses (retention) than did large groups. In 2007 and 2008, small groups paid 120 percent of what large groups did on a pmpm basis towards non-medical spending. In 2009, that figure rose to 141 percent.
- Contribution to surplus (for not-for-profit companies) or profit (for "for-profit" companies) accounted for roughly 25 percent of retention charges built into pricing in all insured market sectors in Q2 2010.

## 2010 Market Changes

- Quoted rates for small groups rose sharply in the first quarter of 2010. Roughly 15 to 20 percent of members in the small group market renewing in the first quarter received quoted rate increases of 35 percent or more. Over half received a quoted rate increase of 20 percent or more.
- In 2009, carriers incurred claims and administrative expenses for comprehensive major medical products equal to 101.6 percent of premium, equating to a 1.6 percent underwriting loss. In 2010, incurred claims and administrative expenses represented 100.0 percent of premium, or a break-even underwriting result.
- Medical loss ratios across all market segments combined, as reported in payer financial statements, decreased from 90.5 percent in 2009 to 89.4 percent in 2010. The decrease in medical loss ratio from 2009 to 2010 appears to be the result of a slowing trend in medical expenditures, both locally and nationally. While medical claims expenditures in Massachusetts increased annually between 6.3 percent and 11.7 percent from 2002 to 2009, they increased by just 3.7 percent from 2009 to 2010. However, it is not yet possible to determine if a decline in growth of medical claims expenses may impact total health care spending. Medical claims expenditures reflect carrier payments and do not include cost-sharing amounts, so changes in the rate of increase may be the result of employers switching to lower value plans when faced with premium increases, also known as benefit buy-down.

## B. Trends in Health Expenditures

### Private Payers

- Private payer health spending in Massachusetts outpaced national health care spending and spending by Medicare and MassHealth. Spending per privately insured member grew 6 percent from 2007 to 2008 and 10 percent from 2008 to 2009. This rate of growth was substantially higher than the increase in national personal health care expenditures per capita from 2008 to 2009. In 2009, national personal health care spending per capita increased 4.6 percent, a deceleration from 4.9 percent growth in 2008.
- Spending by private payers grew faster than spending by public payers. The rate of growth for spending on privately insured people from 2007 to 2008 also outpaced the growth in spending for Massachusetts residents in Medicare (4.8 percent) or MassHealth (2.8 percent) during the same time period. The rates of growth for both private and public payers in Massachusetts continued to outpace increases in per capita state gross domestic product and wages.
- Growth in spending by private payers was largely the result of increasing prices, particularly for inpatient and outpatient hospital services, but also for physician and other professional services. Higher prices explained virtually all of the increase in private inpatient spending from 2007 to 2009. Similarly, increases in prices accounted for about half of the growth in outpatient spending from 2007 to 2008, and virtually all of the growth from 2008 to 2009 (when spending per member year grew 13 percent). For professional services, higher prices explained 77 percent of the growth in spending from 2007 to 2008, and 88 percent of the increase from 2008 to 2009.
- Private spending for drugs was largely driven by price increases in non-generic drugs. Although overall increases in drug spending were more modest than those for other services, price increases for non-generic drugs were a major factor in increased spending. From 2007-2009, the average price of generics grew less than two percent per year, compared with a growth of more than ten percent for non-generics.
- Increased private spending for imaging was driven by higher prices per service. For all types of imaging, higher prices per service—not greater use of imaging services—drove much or all of the growth in spending per member year.
- While there was rapid growth in nearly every category of private insurance spending on a per member year basis, it was most significant for physician and other professional services (21 percent from 2007 to 2009) and outpatient hospital services (more than 23 percent from 2007 to 2009). These two categories of spending accounted for 84 percent of all privately insured spending growth between 2007 and 2009.

## Public Payers

- For MassHealth, inpatient hospital care and professional services were the fastest growing sectors. Outpatient services were the fastest growing for Medicare.
- Growth in Medicare and MassHealth spending predominately reflected increases in service use, rather than growth in prices. Growth in Medicare spending for professional services (1.8 percent) was entirely driven by increased use of services. Similarly, in MassHealth, an eight percent increase in spending per member year for professional services in 2008 corresponded to 8.4 percent growth in service use per member year.
- Increased utilization led to the growth in public payer spending for outpatient hospital services. Nearly all of the growth in Medicare spending per member year for outpatient services (5.1 percentage points of 6.2 percent total growth) was due to increased utilization. Similarly, all of the decrease in MassHealth outpatient hospital spending per member year was due to decreased utilization.
- Growth in public payer spending for imaging was due to increased utilization. For Medicare and MassHealth, growth in spending per member year on imaging was driven more by increased service use and less by changes in spending per service. In both programs, average spending per diagnostic imaging service declined from 2007 to 2008, while the use of diagnostic imaging services per member increased. Spending increases for Medicare for diagnostic imaging was low at 1.8 percent.

## Other Key Findings

- Spending for outpatient hospital services grew much less for public payers than for the private sector. From 2007 to 2008, spending per member year for hospital outpatient care grew 6.2 percent for Medicare and decreased 4.9 percent for MassHealth. This compares with 10.2 percent growth in spending for privately insured hospital outpatient services.
- Inpatient hospital spending growth was slower for Medicare than for the private sector. Inpatient spending for Medicare members increased 4.9 percent per member year, compared with 6.3 percent growth per member year for privately insured inpatient care. MassHealth inpatient spending growth outpaced the private market at 7.9 percent.
- For prescription drugs, growth in private insurance spending lagged behind spending growth in Medicare and MassHealth. Private insurance prescription drug spending per member year fell slightly from 2007 to 2008 as utilization declined but then grew 5.1 percent from 2008 to 2009. This compares with 2007 to 2008 growth in spending per member per year between four and five percent in Medicare and MassHealth, respectively.

- Behavioral health was, by far, the fastest-growing category of privately insured inpatient hospital spending. Although behavioral health accounts for a relatively small proportion of total spending, it grew rapidly from 2007 to 2009. Inpatient behavioral health spending per member year increased 49 percent from 2007 to 2008, and 14 percent from 2008 to 2009. Unlike other types of inpatient expenses, growth in behavioral health inpatient spending was linked to growth in the volume of care.
- A majority of private inpatient spending was devoted to care delivered in tertiary care or specialty and teaching hospitals.[2] In 2009, two-thirds of privately insured inpatient spending was for care obtained in tertiary care or specialty and teaching hospitals, either in the Boston metro area (52 percent) or elsewhere in Massachusetts (14 percent). Just 29 percent of private inpatient spending was for care obtained in community hospitals. For Medicare and MassHealth enrollees, about half of inpatient spending occurred in tertiary care hospitals, while care in community hospitals accounted for 32 percent of spending for MassHealth and 41 percent of spending for Medicare.

## C. Price Variation in Massachusetts Health Care Services

### Price Variation

- Prices paid for the same hospital inpatient services and for physician and professional services vary significantly for every service examined. There was at least a three-fold difference for every service and for most, a variation of six or seven-fold.
- A comparison of median prices paid across hospitals reveals that for inpatient stays such as cesarean deliveries, the highest paid hospitals receive payments that are typically more than double the lowest paid hospitals. For other services such as knee and lower leg procedures, the range is significant but narrower with payment to the highest paid hospital that is 61 percent above the lowest paid hospital.
- Data on the selected 14 routine inpatient services indicates that service volume tends to be concentrated in higher paid hospitals. For example, 47 percent of vaginal deliveries occurred in the most highly paid quartile of hospitals. In general, tertiary care hospitals were more likely to account for a higher proportion of discharges at median prices above the statewide median than community hospitals.

2 Hospitals that offered both cardiovascular surgery and neurosurgery were classified as tertiary care hospitals. Hospitals that did not provide both services but which had teaching programs with 25 or more full-time residents were classified as specialty hospitals. Hospitals with smaller or no teaching program that did not provide cardiovascular surgery and neurosurgery were classified as community hospitals.

## Price Variation and Quality

- There is little measurable variation among Massachusetts hospitals based on the available quality metrics related specifically to the 14 selected inpatient services for which prices are described.
- The lack of variation in the selected quality measures warrants further study if the payment system is going to move to value-based purchasing

## Public Payers and Prices

- Medicaid and Medicare rates were consistently lower than the prices paid by private payers for both inpatient services and physician and professional services.
- There was no correlation between a hospital's share of Medicaid patients and the prices they received from private payers, with some of the lowest paid hospitals having the highest proportion of Medicaid discharges. This finding is inconsistent with providers' and private payers' assertions that higher private payer prices are needed to compensate for losses incurred by serving Medicaid patients.
- Medicare fee schedule rates explicitly consider some of the factors cited by payers and providers that result in different prices paid across hospitals.[3] The variation associated with these factors results in a range in Medicare prices that is similar in breadth to the range found in this report's analysis of private payer prices. However, the relative rankings of hospitals are not correlated between Medicare and private payers. Hospitals that receive higher payments from Medicare are not necessarily the same hospitals that receive higher payments from commercial carriers, suggesting that factors other than what Medicare considers are influencing private payer prices.

3 For Medicare, these factors include: adjustments for area wages, indirect medical education, treating a disproportionate share of low income patients, cases that involve certain approved high cost new technologies, and high cost outliers. For Medicaid, these factors include adjustments for area wages, as well as hospital-specific costs for organ acquisition and malpractice insurance.

# Key Findings from Office of the Attorney General Preliminary Report

The Office of the Attorney General (OAG) conducted analysis of health care prices and payments made to providers by health insurers. Analysis also relied on a review of contracts between providers and insurers, financial and operational strategy documents, documents related to care coordination and care management, and interviews with key stakeholders. The full report is included in Appendix B of this report and has been summarized in six major findings:

- There is wide variation in the payments made by health insurers to providers that is not adequately explained by differences in quality of care.
- Globally paid providers do not have consistently lower total medical expenses.
- Total medical spending is on average higher for the care of health plan members with higher incomes.
- Tiered and limited network products have increased consumer engagement in value-based purchasing decisions.
- Preferred Provider Organization ("PPO") health plans, unlike Health Maintenance Organization ("HMO") health plans, create significant impediments for providers to coordinate patient care because PPO plans are not designed around primary care providers who have the information and authority necessary to coordinate the provision of health care effectively.
- Health care provider organizations designed around primary care can coordinate care effectively (1) through a variety of organizational models, (2) provided they have appropriate data and resources, and (3) while global payments may encourage care coordination, they pose significant challenges.

# Summary of Public Hearing on Health Care Cost Trends

Pursuant to the provisions of M.G.L. c.118G, §6 1/2 the Division of Health Care Finance and Policy (DHCFP) held a public hearing from Monday, June 27 through Thursday, June 30, 2011. The hearing was presided over by DHCFP Acting Commissioner Seena Carrington along with Assistant Attorney General, Thomas O'Brien. Prior to the hearings, DHCFP and the Office of the Attorney General requested written responses to key questions to help inform the discussion at the hearings.

The goal of the hearing was to solicit feedback and foster public discussion under oath as required by Chapter 305 from key stakeholders in the Massachusetts health care delivery system including providers, insurers, employers, and consumers. Presentations of data by researchers and expert witnesses, as well as discussions by key stakeholders from the Massachusetts health care system were designed to foster a more widespread understanding of the nature of the health care cost growth problem facing Massachusetts, but also to debate and develop consensus around actionable solutions that could help mitigate health care cost growth in the Commonwealth.

The public hearings focused on four themes:

- variation of provider prices;
- alternate payment methodologies;
- health resource planning; and
- integration and care coordination

Below is a summary of the key themes that emerged during the public hearing process through both oral and written testimony. The entirety of all written and oral testimony collected by DHCFP is available on DHCFP's Cost Trends website, www.mass.gov/dhcfp/costtrends.

## A. The Urgency and Challenge of Health Care Cost Containment

Participants in the second annual public hearings noted many of the same concerns as in the prior year: rapidly increasing premiums, unsustainable growth in medical expenditures, wide disparities in provider prices, the need for greater coordination of care, and the limitations of the current fee-for-service reimbursement system, among others. Senator Richard T. Moore and Representative Steven M. Walsh, both of the Joint Committee on Health Care Financing, and Representative Jeffrey Sanchez of the Joint Committee on Public Health, reiterated their commitment to addressing these challenges. Governor Patrick spoke about the urgent need for additional cost containment legislation to be passed as soon as possible. At the same time, Governor Patrick cited the Commonwealth's success in enacting universal coverage and achieving a 98 percent coverage rate, as evidence of the Commonwealth's capability to meet formidable challenges. "If anyone's going to crack the code on cost containment, it will be we here in the Commonwealth of Massachusetts," Governor Patrick said.

- Jay Gonzalez, Secretary of the Executive Office for Administration and Finance, noted that Massachusetts is estimated to spend 40 percent of its revenues on health care in state fiscal year 2012, with that proportion projected to increase to 50 percent by 2020. "Health care costs threaten the very viability of government," Gonzalez said, noting how health spending crowds out government spending in other areas such as provision of funding to cities and towns. "Everything we do in government is threatened if we do not address this challenge."
- Small business owner Chuck Green testified regarding the high levels of premiums and deductibles he and his wife face, sometimes deterring them from seeking care. Citing the amount of their yearly insurance premium, he said, "I don't get it. $21,000 and it feels like we don't have any coverage?"
- Public testimony from Amy Whitcomb Slemmer of Health Care for All, as well as Reverend Hurmon Hamilton of the Greater Boston Interfaith organization, called for relief for consumers from escalating premiums.
- Dr. JudyAnn Bigby, Secretary of the Executive Office of Health and Human Services, testified on the need for greater coordination in the health care delivery system. "It's increasingly clear that we need to transform the health care delivery system," Bigby said. "So rather than focusing on the price of an admission or a test or procedure, and how many of these we are paying for, we need to focus on processes of care and clinical practice improvement, and improving quality."

- Many participants noted the interrelated and sometimes interdependent nature of the cost containment approaches discussed, suggesting that any one of the approaches is more likely to succeed in decreasing the rate of growth in health spending if implemented in tandem with other approaches. Nancy Kane of the Harvard School of Public Health testified, "I actually don't believe in [a single most important policy change] because I think all of these things have to happen together or no one thing is going to fix it."
- Participants also noted the shared responsibility between stakeholders—providers, payers, government, employers, and consumers—to find and implement solutions. "We will all continue to be disappointed and we will all look for one culprit or one silver bullet, and it will not work unless we all recognize we all have a responsibility in the answer," said Ellen Zane of Tufts Medical Center.

## B. Price Variation in Massachusetts Health Services

Discussions of price variation during the public hearings were guided by OAG's and DHCFP's findings that large variations in provider prices are a key factor driving health care costs in the privately insured market. Oral testimony reflected near unanimous agreement with these findings, and several witnesses from both providers and payers testified about the role of market power in driving rates. "It is leverage, as defined by market position, location, and brand name that have been the largest drivers of the disparity in rates," stated Normand Deschene of Lowell General Hospital. Multiple solutions were considered, and several witnesses advocated government intervention to ameliorate the problem.

- Witnesses described challenges that lower paid hospitals face in competing with higher paid hospitals. Andrei Soran of MetroWest Medical Center stated, "The more highly paid hospitals and medical groups are using this advantage to grow at the expense of lower priced providers who are losing volume. Higher rates of reimbursement allow the more fortunate providers to pay better salaries, and to attract and retain staff and doctors. They allow for better, newer equipment and facilities, creating marketing advantages. They also fuel expansion plans, further encroaching in new territories at the expense of lower paid providers."
- Hospitals serving a higher proportion of publicly covered patients lack market leverage in negotiating with private payers, according to James Roosevelt, Jr., of Tufts Health Plan, and Ellen Zane of Tufts Medical Center. This results in lower private payer prices for those hospitals compared to hospitals with a greater share of private payer patients.

- Andrei Soran of MetroWest Medical Center, Normand Deschene of Lowell General Hospital, Tufts Health Plan's James Roosevelt, Jr., Paul Hattis of the Greater Boston Interfaith Organization, Dolores Mitchell of the Group Insurance Commission, and Amy Whitcomb Slemmer of Health Care for All supported short-term, temporary government regulation to limit the variation in provider prices.
- A somewhat different proposal was offered by Ellen Zane of Tufts Medical Center, who recommended in written testimony that the government should establish a "uniform base payment format, such as a single base fee schedule, claims submission format, and payment policy and procedures across all payers." This fee schedule could be modified in private discussions between providers and payers based on adjustment factors for approved provider characteristics such as public payer mix, case mix, and teaching status. A similar recommendation was made by Christopher Koller, Rhode Island Health Insurance Commissioner.
- Gary Gottlieb of Partners HealthCare argued that market forces will produce narrower price variation through the adoption of alternate payment methods and the promotion of select and tiered network products.

## C. Consumers' and Employers' Role in Cost Containment

Efforts toward transparency are valued by consumer advocates and hold the promise of helping consumers seek high value care, but most witnesses agreed that these transparency efforts alone would not shift consumer behavior enough to bend the cost curve. Witnesses described several efforts in Massachusetts involving select and tiered network plans offered by employers to their workers, which have the potential to lower health spending by incenting patients to seek care from low-cost, high-quality providers.

- Witnesses noted the importance of public reporting of cost and quality measures, while acknowledging the need for improvement in existing reporting efforts. Paul Hattis suggested the addition of quality measures for more diagnoses and procedures, and the addition of additional outpatient services given a current focus on the inpatient side. Paul Ginsburg of the Center for Studying Health System Change noted that transparency efforts should focus on what the patient pays, not the total payment amount that includes what the insurer pays.
- Many witnesses noted that without incentives, consumers may remain unlikely to shift their care to lower-cost, higher-quality providers. Dolores Mitchell of the Group Insurance Commission stated, "I just think transparency is necessary but not sufficient. There have to be consequences." Paul Ginsburg of the Center for Studying Health System Change reinforced this idea, adding that product designs using select and tiered networks have the potential not only to shift consumer behavior, but also to put pressure on providers to improve the cost-effectiveness of the care they provide.

- Employers and insurers are already offering several select and tiered network products in Massachusetts. W. Patrick Hughes of Fallon Community Health Plan testified on the select network product his organization has offered since 2002, with a 12 percent premium reduction compared to a broader network product covering the same services. In addition, the City of Worcester recently started offering its employees a tiered network product from Fallon called City Advantage, which has helped the City to save millions of dollars and more than 100 jobs through resulting cost savings.
- The Commonwealth of Massachusetts, in its capacity as an employer, has also implemented select and tiered network products. Dolores Mitchell of the Group Insurance Commission described her organization's most recent initiative, which provided an incentive of a three-month premium holiday to employees switching to a select network plan. With 30 percent of state employees now enrolled in select network plans, the state is projected to save $30 million in fiscal year 2012, due to the lower premiums for these plans which restrict members to low-cost, high-quality providers.
- There was broad agreement that insurance product design must support informed consumer decision-making, with many witnesses praising the GIC program. In their written testimony, Atrius Health stated that "the GIC's recent enrollment efforts were a great example of an employer working with its employees around limited health plan networks and tiered products. Consumers need to understand the plan product that they select, their financial responsibilities under that plan (e.g. co-pays and deductibles), that 'more care' is not necessarily better care, and that there are limitations to where they can go for care."
- Tiered and select network products support the creation of integrated networks that can receive global payments, particularly in plans that require the selection of a primary care provider. "It's very hard if patients are going all over the place to hold the physician accountable for what happens to them," Dolores Mitchell observed.

## D. Alternate Payment Methodologies

Among a group of witnesses asked to comment, there was consensus that the Commonwealth should shift from fee-for-service reimbursement to alternate payment methodologies within five to ten years, and that global payments were the ultimate goal. Witnesses acknowledged that the transition to global payments would take time and that interim steps along the way may be necessary. New investments in primary care and data systems will be needed to enable providers to manage risk. Witnesses discussed several potential roles for state government to actively promote alternate payment methodologies or to oversee their adoption by private payers and providers.

- Work by payers and providers in the Commonwealth offers several examples of implementation of alternate payment methodologies. Evan M. Benjamin of Baystate Medical Center presented results from the Baystate Best Care Program, a bundled payment pilot for total hip replacement. Results for the first 30 cases covered under this program showed a decrease in readmissions and complications, as well as an increase in patient satisfaction. Patrick F. Gilligan of Blue Cross Blue Shield of Massachusetts discussed implementation of global payments under the Alternative Quality Contract, which currently includes 12 provider groups in Massachusetts serving 45 percent of the company's HMO members. Data from the first year of the program have shown improvements in both quality and efficiency.
- Data is key to enabling payers and providers to set new payment levels and to coordinate care, according to Harold D. Miller of the Center for Healthcare Quality and Payment Reform and Evan M. Benjamin of Baystate Medical Center. David Polakoff of MassHealth and the University of Massachusetts Medical School concurred and noted that providers would need to make investments in training and staffing to enhance their ability to use data and manage risk.
- Primary care providers (PCPs) should direct patients to appropriate, efficient care under these new models, according to David Polakoff, and to Joseph Berman of Acton Medical Associates. Berman testified, "For health care costs to be controlled, every patient must have a primary care physician who directs their care. PCPs are in the best position to manage the care of their patients in a high quality, cost-effective, and appropriate manner."
- All panelists present at the discussion of alternate payment methodologies agreed that the report from the OAG highlighted the need to ensure that current disparities in payment and medical expense are not incorporated under alternate payment methodologies. Witnesses highlighted the importance of continued transparency of cost and quality information.

- There are several potential roles for state oversight under alternate payment methods, such as setting definitions and parameters for alternate payment systems and monitoring any provider consolidation that may accelerate as providers adapt to managing risk. Nancy Kane of the Harvard School of Public Health suggested the state government should monitor provider price differentials and ensure that implementations of alternative payment methodologies serve the state's goals. "We need an independent oversight body to make sure that the game that we want to set out is really played according to the rules that people believe in and trust and results in better quality, more affordable care for the Commonwealth," she testified. Others, including Evan M. Benjamin and Patrick F. Gilligan, testified that the state should promote the adoption of alternate payment systems by implementing them within its own programs such as MassHealth and the Group Insurance Commission.
- Due to their lack of leverage with private payers, safety net providers are currently disadvantaged in implementing alternative payment methodology pilots, and are at risk for lagging behind higher-priced providers in payment reform efforts. Cambridge Health Alliance stated in written testimony that they and other safety net providers "don't qualify for currently available private payer models (such as the Alternative Quality Contract) because of the small size of each private payer's membership assigned to CHA." Safety net providers will need special consideration as alternative payment methodologies are expanded to avoid baking in current market inequities. Harold D. Miller emphasized the need to promote a transition to global payments using incremental methods such as episode-based payments, condition-specific capitation, and partial global payments. Miller testified that realizing the potential savings of these new systems takes time, and global payments need to be based on multi-year contracts for providers to realize returns.

## E. Health Resource Planning

Discussions about health resource planning in the Commonwealth focused on the opportunities that medical innovation may provide for cost containment and the investments in public health, infrastructure, information technology, and workforce development necessary to meet the demands of greater provider integration. In the course of the public hearing, Expert Witness Cathy Schoen and the panelists agreed that we need to better leverage existing resources to meet patients' needs. A DHCFP presentation highlighted the need for expansion of the primary care workforce. The Department of Public Health's Determination of Need process was examined, with the consensus that authority and capacity required strengthening. Witnesses also spoke about the role of community health centers and primary care capacity in a reformed health care delivery system.

- Witnesses discussed the need for increased health resource planning to identify system inefficiencies and ensure that Massachusetts residents' needs are met while avoiding excess capacity. Julie Pinkham, representing the Massachusetts Nurse Association, stated that redundant but high-priced resources have been able to proliferate in the absence of a robust Determination of Need process. DPH Commissioner John Auerbach discussed the creation of a Division of Health Planning as proposed in the Governor's health care bill which would be responsible for developing a biannual state health plan. Commissioner Auerbach testified that the health plan would include "an inventory of current health care facilities and assessment of the need for services, compared to the supply that currently exists," and that this information could be used to examine "in much greater detail, the patterns of utilization and the factors associated with preventable hospitalizations and other types of utilization that we either want to encourage or discourage." Auerbach also mentioned the importance of data to inform these efforts, suggesting that analysis of DHCFP's hospital case mix data and All-Payer Claims Database (APCD) could help to guide health resource planning.
- The question of how to address capacity that may become excessive as improvements are made to system efficiency highlighted the need for simultaneous payment reform so that high-value providers are not penalized for delivering high quality services. Allison Bayer, of Cambridge Health Alliance, related the institution's experience with a pediatric asthma prevention program that resulted in a decrease in hospitalizations, and stated that "excess capacity as you actually improve health outcomes that change the way you deliver care" must be distinguished from excess capacity due to unnecessary resource expansion.

- Many witnesses emphasized the value of primary care and prevention in leveraging and allocating existing health resources. In his written testimony, Richard W. Silveria, of Boston Medical Center submitted examples of how primary care can be cost-effectively expanded to mitigate shortages, noting that Boston Medical Center has "created open access scheduling in its primary care practices; carved urgent care out of its emergency department; [and] extended walk-in hours at night and on weekends in its affiliated community health centers to better serve patients."
- Several witnesses noted the need for workforce development, as well as the potential for shifting employment capacity as the health care delivery system is reformed. Representing SEIU Local 1199, Veronica Turner noted that a more efficient health care system would likely result in "less jobs in acute care facilities, and a potential to have more jobs in the community and at community health centers, which is why we're focusing on retraining the workforce so that they meet those needs."

## F. Challenges in Care Coordination

Improving how various providers work together to care for patients is a cornerstone of all proposed efforts to reform the healthcare delivery system. An absence of adequate care coordination is a key failing of the current system and a direct cause of waste and inefficiency. DHCFP findings identified several areas for improvement in care coordination, as evidenced by preventable hospitalizations and readmissions, and avoidable emergency department (ED) utilization. Expert Witness Jody Hoffer Gittell highlighted the importance of relational coordination, including improvements in communication and teamwork by health professionals as a goal in improving coordination. The testimony consistently emphasized the importance of better connections between physicians, hospitals, post-acute care facilities, and particularly, behavioral health practitioners. Concrete examples illustrated how to address the challenge of fractured, piecemeal care and progress to an integrated, efficient system.

- Findings presented by DHCFP suggest that a significant portion of high-cost care in Massachusetts results from inefficiency in the health system that can be ameliorated through better provision of primary care. In particular, nearly half of ED visits in 2009 were considered preventable or avoidable. Moreover, results from a federally-funded ED diversion program suggest that strategies such as increasing primary care capacity and strengthening medical home linkages can decrease ED use. Most of the 17 participating community health centers observed a decrease in the proportion of ED visits considered preventable or avoidable, as well as those for ambulatory care sensitive conditions.

- Although care coordination has the potential to improve patient care, it is not properly incentivized under the current payment system. Laurie Sprung, of the Advisory Board Company, testified that "we see the overwhelming majority of organizations running hard at readmissions because it's the right thing to do, but recognizing that their financial performance today is going to be hurt by that and that's a failure in the system that we are penalizing providers for doing the right thing." Without financial alignment across the care continuum, improvements in coordination pose a significant challenge to providers who depend on the revenues from readmissions, emergency department visits, and preventable hospitalizations.
- Many stakeholders agree that the role of primary care providers is integral to ensure appropriate coordination of care within an integrated delivery system. Joseph Berman, of Acton Medical Associates, stated in his written testimony the need for giving primary care providers a prominent role in care management through "requiring patients to choose a primary care provider and empowering the PCP to manage their care. PCPs refer patients for appropriate care when clinically indicated, thereby eliminating unnecessary and excessive testing and treatment that occurs when patients self-refer. Physicians are best qualified to determine appropriate testing and treatment plans."
- Michael Cantor of the New England Quality Care Alliance emphasized this point in his oral testimony, stating that "all patients should select a primary care provider. One major barrier to accomplishing the Triple Aim[4] is that primary care providers are not given resources to effectively manage and coordinate care for most of their patient panels." Expanding the number of patients whose care is effectively managed by primary care providers is a promising mechanism for eliminating waste in the delivery system.
- Unnecessary differences in clinical practice is an easy target for reducing costs and improving quality of care. In her public testimony, Barbra Rabson of Massachusetts Health Quality Partners (MHQP) reflected that "much of the variation in clinical practice is attributable to physician preference, habit, and training, rather than patient preference, severity of illness, or outcomes of care … Variations may indicate either overuse of services that do not improve health care, or underuse of preventive care services, that can improve health and help patients avoid the need for more costly types of care. The latest MHQP data shows significant variation among Massachusetts medical groups for managing such conditions." Through integrating care, various providers are better equipped to work together to reduce practice variation. Dennis Chalke noted in his written testimony on behalf of Baystate Medical Center that "BMC has undertaken many initiatives to reduce clinical practice variations, thus improving quality and reducing costs. This concept should be fully expanded to care provided outside of the hospital through the development of continuum of care practice guidelines."

4 The "Triple Aim" is defined as improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care for populations. See Berwick D, Nolan TW, and Whittington J (2008). The Triple Aim: Care, Health, and Cost. *Health Affairs*, 27(3), 759-769.

- There was broad consensus that effectively integrating behavioral health services into the delivery system was key to lowering costs and improving quality of care. Barbara Leadholm, Commissioner of the Department of Mental Health, stated in her oral testimony that "we know that individuals with untreated mental illness or substance use disorders experience higher rates of comorbid conditions, requiring increased medical treatment. To address quality and cost efficacy, we must assure early access to mental health and substance use prevention, treatment, and recovery services." Ralph de la Torre, of Steward Health System, echoed this point in the panel discussion, noting that "no single service benefits more from global payment reform than behavioral health because there is an immediate impact of keeping those patients healthy."
- Payers also have a significant role to play in improving provider coordination. In written testimony for Blue Cross Blue Shield of Massachusetts, Patrick Gilligan related several instances in which the Alternative Quality Contract allowed providers to invest in "important infrastructure and other improvements, such as care managers and electronic data sharing between physicians and the hospital. [Such] infrastructure investments will help provider organizations deliver care more effectively and efficiently."
- Written and oral testimony also pointed to the role of integrated care organizations (ICOs, also commonly referred to as accountable care organizations, or ACOs) in fostering increased coordination of care. In his oral testimony, Ralph de la Torre of Steward Health Care System stated, "Providers need to build an infrastructure that coordinates, manages, and integrates care…We need to have the resources to build the appropriate IT platforms, quality systems, care integration, and coordination. Whether you call it an ACO, an HMO, a patient-centered medical home, or any other acronym, this level of clinical and financial integration is the future of successful health care delivery." Similarly, Jack Dutzar of Fallon Clinic submitted written testimony stating, "With the major features of an ACO being capitated payment, measurable quality, and demonstrated efficiencies and alignment with a hospital partner, we feel we are well qualified to operate within this model [and] are convinced that value-based purchasing involving fixed payments with reimbursement being linked to quality and cost is the future."
- As the health care delivery system evolves to promote increased coordination of care, the quality measures used to track the health system may also need revision. Several provider organizations submitted written testimony stating that existing quality measures are not sensitive enough to reflect differences in care between providers. Baystate Medical Center noted that providers have adapted to perform well against these measures, suggesting that new measures will need to be adopted in order to better understand progress in system improvements. Atrius Health wrote that existing ambulatory quality measures track care over a single visit, whereas new health care delivery models and payment methods would benefit from measures that track episodes of care.

## G. Role of Government and Market in Reducing Health Care Costs

Witnesses agreed over the course of the Cost Trends public hearing process that comprehensive system reform will require an ongoing cooperative partnership between the public sector and the health care industry. Some government interventions were discussed as necessary to guide and support the marketplace in finding equitable solutions to current imbalances, particularly where market-based solutions are slow to emerge. Expert Witnesses testified that government regulation should serve to support more efficient markets and to support the provision of public goods. As Rhode Island Insurance Commissioner Christopher Koller testified, "Even if you have individuals more engaged in purchasing the parts of medical care that are commodities, a whole bunch of consumers empowered by smart phones and smart benefits are not going to be able to invest in public health, accomplish provider payment reform, improve care coordination when they're ill, define the central health benefits and resource constraints, revitalize primary care, or curb institutional power and self interest." Although witnesses recommended a combination of complementary government and market-based strategies to accomplish health care reform, they had contrasting views on the specific role of government in addressing problems.

- Many stakeholders saw access to timely data from an interoperable provider or payer network as key to informing this process. Ray Campbell of the Massachusetts Health Data Consortium, as well as Commissioner Barbara Leadholm of the Department of Mental Health noted that creation of a robust database of health information by any single private organization would create a major challenge given that patients frequently move between payers and providers. In his written testimony, Eugene Lindsey of Atrius Health went a step further and referenced "the need for a 'medical commons'; finding a way to share our common resources for the good of the community. Particularly in a state where so many of our healthcare organizations are mission-driven non-profits, this should be the norm and not the exception. Government can facilitate these discussions by providing strong data about capacity and resources in advance of the issues and opportunities that could potentially arise." Having data from these various sources is necessary but not sufficient in completing the solution, as the way the data are combined and organized is key to making it useful. Expert Witness Jody Hoffer Gittell noted that "the state role could be to create this common data infrastructure that allows the systems to connect."

- Panelists discussed the potential for government to act not only in a data dissemination or regulatory capacity in order to incent the market to reform the health care delivery system, but as a significant purchaser of benefits for state workers and low-income residents. By throwing its weight behind alternative payment methodologies, panelist Laurie Sprung identified a "meaningful role for state government, in terms of creating critical mass, in terms of differentially contracting in its role as an employer, with those provider networks who are organized for value."
- Glen Shor, Executive Director of the Commonwealth Health Insurance Connector Authority, discussed how the Connector has used its procurement process to incentivize insurers to offer lower cost, high quality products for members in Commonwealth Care, Massachusetts' coverage program for low-income adults with incomes up to 300 percent of the federal poverty level. For some segments of its membership, the Connector has rewarded low-bidding health insurers by assigning extra membership to these insurers' plans. In addition, the Connector's use of select networks has been the main factor in a 15 percent reduction in the capitation rate for one of the Connector's participating carriers in fiscal year 2012.
- Many witnesses expressed concerns over the growing consolidation of large providers in the Commonwealth, and supported government action against potential antitrust violations. While such action is appropriate in some cases, Christine White, of the Federal Trade Commission, advocated caution in seeing antitrust action as a panacea, stating that "antitrust does not pick winners and losers, in terms of particular providers, products, services, or business models. In a competitive marketplace, providers and health plans have incentives and significant latitude under the antitrust laws to develop and implement new products and services, as well as novel financing and delivery arrangements, without raising antitrust concerns."
- Rhode Island Insurance Commissioner Christopher Koller warned policymakers against using the insurance rate review as a singular tool to correct the health care cost curve, stating that "insurance rate review is necessary, but not sufficient, for an affordable health care system. It creates transparency, accountability, and if we do it right, a system focus, but it does not reduce the cost drivers inherent in the medical system." In order to support payment and system reform, many stakeholders agreed that government could play a crucial analytic support role. Noting that many shared risk arrangements between payers and providers could change the algorithms that are used to determine the level of reserves payers must have available in order to remain solvent, Ralph de la Torre spoke about the potential for the state to "come up with an actuarial methodology to evaluate what risk reserves are required and how to treat shared risk payment reform models."

# Recommendations for Health Care Cost Containment in Massachusetts

## A. Opportunities to Address Rising Costs

The findings from DHCFP's preliminary reports and other relevant analyses, the investigation by the Office of the Attorney General, and the testimony prior to and during the public hearings identified many opportunities to reform the health care system and increase both the efficiency and quality of care delivered in the Commonwealth. In particular, there was broad consensus on the following key opportunities for developing policy solutions:

- The current health care infrastructure is ill-equipped to support the provision of coordinated care in Massachusetts. Investments in information technology, workforce development, primary care, and public health and wellness are necessary to improve the efficiency of health care.
- Variation in provider prices for common services is broad. This variation correlates to market leverage and may give high-priced providers an unfair advantage to the extent that variation is based on market position, location, and brand name.
- Fee-for-service reimbursement, which is the dominant form of provider payment in the Commonwealth, perpetuates an inefficient and fragmented health care system, while penalizing providers that seek to improve the coordination of care for their patients and eliminate waste in their practices.
- Many currently available insurance products do not present consumers and employers with incentives to make efficient, high-quality health care purchasing decisions.

The hearings emphasized not only the importance of each of these areas for improvement, but the extent to which they are interrelated. There is broad consensus that these issues cannot be resolved individually, but must be addressed in the context of comprehensive, system-wide reform.

## B. Overview of Recommendations

The following section elaborates on DHCFP's policy recommendations to address the rising cost of health care:

- Increased alignment of health care payments with value, through use of alternative payment methods and steps to address unjustified provider price disparities.
- Increased integration of providers into integrated care organizations (ICOs) with the capacity to provide coordinated care to patient populations.
- Oversight by government agencies to support health system redesign and the implementation of alternative payment methodologies.
- Development of primary care capacity, care coordination, and insurance products that incent consumers to seek care in lower-cost settings.
- Transparency of both quality and price metrics for consumers, providers, and payers.
- Investments in infrastructure necessary to improve efficiency of health care delivery.
- Investments in public health to promote wellness.
- Development and standardization of quality measures that track health system redesign goals.

Many of these recommendations are related, and a piecemeal approach to their implementation would likely limit their impact. The potential for the Commonwealth to lower health care costs and improve quality depends on the success of comprehensive efforts to reform payment mechanisms and the delivery of care.

## C. Recommendations

### 1. Increase coordination of care by aligning health care payments with value

In order to transition the health care delivery system in Massachusetts towards greater efficiency and integration, DHCFP recommends that comprehensive payment reform be implemented. This proposal builds on the repeated recommendations of experts and stakeholders at both the state and national level and acknowledges published findings that demonstrate that health care spending grows at a slower rate under global payment arrangements while quality improves (Song Z. et al. NEJM 2011; 365: 909-918). In his written testimony describing Blue Cross Blue Shield of Massachusetts' experience with global payments under the Alternative Quality Contract, Patrick Gilligan noted that in several instances these arrangements had allowed providers to make "important infrastructure and other improvements, such as care managers and electronic data sharing between physicians and the hospital." As payment methods support provider activities to focus on keeping patients healthy, carefully manage patients with chronic conditions, and efficiently deliver care to hospitalized patients when necessary, the Massachusetts health care system will align incentives for providers, payers, and consumers regarding the provision and use of high quality, cost-effective care.

Witnesses also noted that the current fee-for service system provides some disincentives for providers who aim to improve the quality of care. As Laurie Sprung of the Advisory Board testified, "we see the overwhelming majority of organizations running hard at readmissions because it's the right thing to do, but recognizing that their financial performance today is going to be hurt by that and that's a failure in the system that we are penalizing providers for doing the right thing." The framework for payment reform will remove the inflationary incentives inherent in the fee-for-service system, reward integrated care delivery, and mitigate cost growth over time by reducing expenditures on unnecessary and avoidable care.

Alternative payment methodologies that support the functions of integrated care organizations (ICOs) should be a targeted focus for both private and public payers. DHCFP supports the Governor's health care bill, which promotes alternative payment methodologies such as global payments, shared savings arrangements, bundled payments, and episode-based payments. These methodologies are designed to compensate ICOs and other providers for effectively managing a patient population and increasing their capacity to coordinate patient care, and allow for a reasonable margin for capital improvement and other initiatives.

A shift to comprehensive payment reform, while essential for controlling health care costs, will create changes for both providers and payers alike. "Not everybody is going to be prepared to leap all the way to a global payment system or to a full episode based payment system right away," according to Harold D. Miller of the Center for Healthcare Quality and Payment Reform. As several witnesses and stakeholders testified during the public hearings, the shift to alternate payment methods may be facilitated through transitional methods. For example, providers may be permitted to adjust gradually to greater levels of risk if bundled payments are implemented in the short-term future, with global payments to follow in several years. The transition will also be eased as concurrent policy changes related to concepts such as ICOs and patient-centered medical homes contribute to providers' greater ability to manage the care of their patients. As providers take on more risk, the amount of risk carried by health plans will diminish and potentially decrease the amount of reserves needed by those payers. At the same time, providers may need to make new investments in health information technology and staffing in order to more effectively coordinate care and manage risk.

As indicated in DHCFP's and the OAG's analysis and findings as well as oral testimony from several experts and stakeholders, simply transitioning to an alternative payment methodology without addressing underlying provider price variation will limit the extent of resulting cost savings. Some variation in health care prices is justifiable to account for factors such as differences in quality of services, institutional teaching obligations, and the proportion of patients served that have higher than average acuity. Indeed, Medicare pays providers differentially based on adjustments for area wages, indirect medical education, treating a disproportionate share of low-income patients, cases that involve certain approved high cost new technologies, and high cost outlier payments.[5] However, given that current levels of price variation may be a contributing factor of the overall rise in health care spending, and are not correlated with provider quality or other factors that are widely acknowledged as reasonable, nearly all stakeholders agree that existing unjustified price variation should be mitigated to avoid additional rise in health care spending. As Ellen Zane of Tufts Medical Center testified, "price convergence is imperative for a healthy and sustainable market."

Although a variety of broad, long-term reforms are necessary in order to contain costs and transition to a more efficient delivery system, the immediate economic imperative is such that short-term government intervention is critical to providing relief to businesses and families in the Commonwealth. Executives of several Massachusetts hospitals testified during the public hearings that they would support this approach. Additionally, Rhode Island Health Insurance Commissioner Christopher Koller used his testimony at the public hearings to describe his state's experience with reviewing commercial health insurance rates and underlying factors, including provider prices. This process, Koller said, has fostered greater transparency and public awareness of the drivers of health care costs.

5 Medicare Payment Advisory Commission, Medicare Payment Basics: Hospital Acute Inpatient Services Payment System, October 2010. Available at: documents/MedPAC_Payment_Basics_10_hospital.pdf, accessed 5/22/2011.

Given the strong consensus that short-term government oversight of provider rates is necessary to curb price disparities, DHCFP recommends that the Division of Insurance (DOI) premium rate review process be strengthened through legislation. Chapter 288 of the Acts of 2010 enacted a limited rate review process by which DOI was granted the authority to disapprove premium rate increases deemed excessive; however, that legislation did not extend to oversight of provider rate increases. Under the Governor's proposed health care bill, the DOI would have additional authority to take into account provider rate increases and provider rate disparities when considering whether premium increases are justified. This would provide Massachusetts with a blunt but necessary tool to address the price inequities in the health care marketplace, and disapprove excessive premium rate increases due to provider prices increases that are not derived from justifiable factors.[6]

Other government interventions may need to be implemented as well, although there is limited consensus on what successful interventions might entail. The Special Commission on Provider Price Reform, established under Section 67 of Chapter 288, recently convened to specifically examine the factors that may influence price variation and has further developed policy recommendations around this issue.[7]

### 2. Promote the integration of providers to deliver coordinated, comprehensive care

Written and oral testimony described the need to foster provider organizations that would be responsible for the full continuum of health care received by their patients. In his oral testimony, Ralph de la Torre of Steward Health Care System stated, "Providers need to build an infrastructure that coordinates, manages, and integrates care…We need to have the resources to build the appropriate IT platforms, quality systems, care integration, and coordination. Whether you call it an ACO, an HMO, a patient-centered medical home, or any other acronym, this level of clinical and financial integration is the future of successful health care delivery." Similarly, Jack Dutzar of Fallon Clinic submitted written testimony stating, "With the major features of an ACO being capitated payment, measurable quality and demonstrated efficiencies and alignment with a hospital partner, we feel we are well qualified to operate within this model [and] are convinced that value-based purchasing involving fixed payments with reimbursement being linked to quality and cost is the future."

6 The justifiable factors identified in the Governor's proposed health care bill are the rate of increase in the gross domestic product or consumer price index, the rate of increase in total medical expenses (TME), a provider's rate of reimbursement with a carrier, especially in relation to the carrier's statewide average relative price, and whether the carrier and a contracting provider or accountable care organization are transitioning from a fee-for-service contract to an alternative payment contract.

7 The Special Commission on Provider Price Reform is specifically charged with examining "(i) the variation in relative prices paid to providers within similar provider groups; (ii) the variation in costs of providers for services of comparable acuity, quality and complexity; (iii) the variation in volume of care provided at providers with low and high levels of relative prices or health status adjusted total medical expenses; (iv) the correlation between price paid to providers and (1) the quality of care, (2) the acuity of the patient population, (3) the provider's payer mix, (4) the provision of unique services, including specialty teaching services and community services, and (5) operational costs, including labor costs; (iii) the correlation between price paid to providers and, in the case of hospitals, status as a disproportionate share hospital, a specialty hospital, a pediatric specialty hospital or as an academic teaching hospital; and (v) policies to promote the use of providers with low health status adjusted total medical expenses." See Chapter 288 of the Acts of 2010, § 67.

The development of integrated care organizations (ICOs) as outlined in the Governor's health care bill would ensure that providers work collaboratively to meet patient population needs. It would also foster the enhanced coordination of care necessary for comprehensive payment reform as described above. Steps would need to be taken to ensure that ICOs share responsibility for the cost of patient care and primary responsibility for the quality of care delivered. ICOs should be composed of licensed and accredited health care providers centered around primary care, and include acute hospital care and behavioral health. DHCFP would establish standardized licensing requirements for the formation of ICOs and parameters for quality measurements to be used in evaluations of their performance.

The Governor's bill calls for ICOs to meet certain minimum requirements essential to meeting the needs of a diverse patient population including:

- Clinical service coordination, management, and the ability to provide integrated health care services through its ICO provider network in accordance with the principles of a patient centered medical home.
- Population management functions, including health information technology and data analysis tools to monitor patient-specific and aggregate data.
- Financial management capabilities, including claims processing and payment functions for ICO network providers.
- Network provider contract management capabilities.
- Quality measurement competence, including the ability to measure and report performance on standardized quality measures.
- Patient and provider communications functions.
- The ability to provide behavioral health services either internally within the ICO or by contractual arrangement.

By establishing a common framework from which ICOs will function and deliver care, state government can ensure that health system reform will improve the capacity of providers to effectively coordinate and develop more efficient care processes in a consistent, replicable way.

### 3. Ensure that government oversight of the transition to payment reform and system redesign is coordinated and tracks appropriate outcomes

DHCFP concurs with the recommendation issued by the OAG in its preliminary report that there is a need to "develop appropriate regulations, solvency standards, and oversight for providers who contract to manage the risk of insured and self-insured populations." Testimony provided by several witnesses during the public hearings also indicates the value of increased government oversight as the market adopts cost containment measures. Nancy Kane of the Harvard School of Public Health testified, "We need an independent oversight body to make sure that the game that we want to set out is really played according to the rules that people believe and trust and result in better quality, more affordable care for the Commonwealth." Paul Ginsburg of the Center for Studying Health System Change testified that as benefit designs continue to change (e.g., the implementation of tiered and limited networks), there will be a greater need for government oversight over those products.

As the Commonwealth works to mitigate health care cost growth and restructure its delivery system, an entity to guide its decision-making and implementation strategy must be designated. At present, multiple state agencies share responsibility for various components of provider monitoring, health insurance premium review, and quality and performance measurement. Indeed, witnesses at the hearings noted a wide range of areas in which government oversight would be useful, including reviewing premium rate increases, setting guidelines for alternate payment methods, monitoring provider consolidation, and creating standards for data and the reporting of cost and quality measures. In Nancy Kane's words, the state would need to be "the rule setter and a little bit of the umpire afterwards."

Despite the variety of areas for which government oversight may need to be enacted and coordinated, there is no public entity to set overall targets for progress in health care reform or to coordinate public agency efforts to improve the health system efficiency. DHCFP supports the establishment of a coordinating council, as outlined in the Governor's health care bill, to establish a plan of action, timeline, benchmarks, and standards to ensure and facilitate comprehensive payment reform and system redesign. The coordinating council would be responsible for making recommendations to relevant public agencies and private stakeholders relating to pricing, reimbursement methods, and quality measures to be utilized in contracts for accountable care organizations; the minimum criteria and other parameters for the formation of accountable care organizations; and market parameters relevant to the development of fair, effective, efficient and sustainable global payments or other alternative payment methodologies in the purchase of health care services.

To ensure that efforts to move forward with system reform are aligned, the council would monitor policies between public agencies for consistency. The council would also coordinate with relevant federal agencies regarding regulations and other forms of guidance, so that the Commonwealth can continue to lead the nation as an innovator of health system design.

The coordinating council and its advisory committee would include a broad representation of public and private stakeholders to support buy-in from the health care community for recommendations and reform efforts. The entities represented would include the Executive Office of Health and Human Services, the Department of Mental Health, the Office of Medicaid, the Massachusetts Hospital Association, Massachusetts Association of Health Plans, as well as behavioral health providers, and consumer health advocacy organizations.

In addition to the coordinating council, existing government agencies will have a key role to play in monitoring the health care system throughout upcoming policy changes. As described above, the Division of Insurance will review premium rate increases as directed by Chapter 288, and would have expanded authority under the Governor's proposed health care bill to take into account provider rate increases when conducting this review. During a time of transition in payment methods and integration of health care providers, such oversight may serve to ensure greater equity and more moderate growth in premiums.

### 4. Encourage consumers to use the most appropriate settings for their care

Findings on avoidable ED visits and preventable hospitalizations, as presented by DHCFP at the public hearings, indicate that many patients are seeking care in high-cost acute settings when their conditions could have been treated in an ambulatory care setting or avoided through receipt of preventive care. Providers in Massachusetts have started to address this high-cost, inefficient use of health care services through strategies such as a federally-funded ED diversion grant program administered by 17 community health centers and expansion of open access scheduling and walk-in hours by primary care practices and community health centers affiliated with Boston Medical Center. DHCFP recommends that such initiatives be strengthened and expanded, noting that these goals are consistent with the recommendation of adoption of alternative payment methods and ICO-like initiatives to improve care coordination.

At the same time, opportunities exist to modify incentives not only on the provider side but also on the consumer side in order to encourage consumers to seek care in lower-cost settings. The variation in prices paid to providers demonstrates an opportunity to incent consumers to make more cost-effective choices about health care through new insurance product designs that direct care to efficient, lower cost providers. Several witnesses testified during the public hearings on the value of benefit design in this regard. Paul Ginsburg of the Center for Studying Health System Change testified that while price transparency via reports from DHCFP and the OAG, as well as through hospital cost and quality measures displayed on the *My Health Care Options* website is useful for policy-making, incentives provided through benefit design are the key to changing consumer behavior. According to Ginsburg, select or tiered provider networks have the potential not only to incent consumers to switch to high-quality, low-cost providers, but also to put pressure on lower-quality, higher-cost providers to improve the cost-effectiveness of the care they provide.

Various government efforts have been implemented recently to promote the availability of insurance products such as select or tiered provider networks. Chapter 288 of the Acts of 2010 included a provision that enabled the Division of Insurance to require that every insurer that participates in the merged market create and offer to all participating employers and individuals a product which includes a select network of high-quality, low-cost providers. Early reports on the implementation of this measure indicate increasing consumer and employer interest in such products. Blue Cross Blue Shield of Massachusetts reported in their public testimony that their Options product has grown five times over since 2009, and that their Hospital Choice Cost-Sharing product has experienced the fastest launch in the organization's history.

Select networks have also been one of several cost containment methods employed by insurers serving members in Commonwealth Care, Massachusetts' coverage program for low-income adults with incomes up to 300 percent of the federal poverty level. Glen Shor, Executive Director of the Commonwealth Health Insurance Connector Authority noted that this approach was the main factor in a 15 percent reduction in the capitation rate for one of the Connector's participating carriers in fiscal year 2012.

Similarly, the Group Insurance Commission (GIC) adopted a number of products with provisions that allow for differing levels of cost sharing based on tiers of providers within the network. By requiring all active employees to re-enroll in health coverage and providing a three month "premium holiday," over 17,000 employees enrolled in lower-cost tiered network plans. This switch is estimated to save the Commonwealth $30 million in the next fiscal year. Given the potential for substantial cost savings and widespread public acceptance, such products should be studied and evaluated in more detail to better understand whether they achieve cost-savings and the accompanying outcomes in terms of access and quality of care.

### 5. Promote the transparency of health care price and quality information

Purchasers of health care, particularly employers and consumers, need access to relevant health care cost and quality data. Harold D. Miller of the Center for Healthcare Quality and Payment Reform, and Paul Hattis of the Greater Boston Interfaith Organization, noted that existing quality measures are limited and too often provided separate from cost information. Hattis suggested the addition of quality measures for more diagnoses and procedures, as well as quality measures for additional outpatient services given a current focus on the inpatient side. In addition, several stakeholders including Paul Hattis and Evan Benjamin, both of Baystate Medical Center, testified that analysis of existing global payment arrangements in the OAG preliminary report demonstrates the need for continued monitoring of provider pricing levels even as the health system transitions to alternative payment methods. Ongoing monitoring of these prices can ensure that existing price disparities between providers do not persist after new payment methods are implemented. Further, Nancy Kane of the Harvard School of Public Health mentioned transparency around price disparities, as well as promoting a standardized way of presenting such information, as a potential role for the state in its role of facilitating and overseeing payment reform.

To this end, the Health Care Quality and Cost Council has been collecting insurance carrier claims data on the privately, fully insured for four years, and currently posts data on inpatient and outpatient conditions, procedures, and diagnostic tests on its consumer website, *My Health Care Options*. The continued development of cost and quality metrics are key to ensuring that consumers have the tools they need to make informed decisions about where to obtain high-quality, cost-effective health care. In order to increase the availability of such cost and quality metrics, it is critical that claims data from all self-insured and fully-insured payers in the Commonwealth be collected.

Transparency is critical in the context of payment and delivery system reform; information on negotiated provider prices should be publicly available and easily accessible to consumers, employers, insurers, and researchers. The Governor's health care bill outlines mechanisms by which DHCFP will provide access to information on the development of ICOs, including the following:

- Data pertaining to health care quality;
- Analyses of data to assess trends in performance, the impact of the transition ICO delivery systems, including changes in the workforce, trends in primary care physician capacity, and changes in health care provider practice operations, and including progress toward shared responsibility for the needed infrastructure, legal, and technical support for providers;
- Examinations that monitor provider and ICO acquisition and implementation of health information technology; and
- Standards for obtaining patient consent for sharing information regarding patient care across all providers within a patient centered medical home and ICO.

Although transparency alone will not slow the growth of health care costs, public efforts to monitor and report on provider prices will assist stakeholders in addressing key policy decisions in health system reform.

### 6. Develop public databases that enable analysis of health care spending, utilization patterns, and provider quality while promoting administrative simplification

The availability of system-wide data on health care cost and utilization patterns is key to monitoring trends, highlighting areas of opportunity, and spotting potential obstacles to health system reform. Given that patients travel between different provider and payer organizations, it would be very difficult for any single private organization to compile a rich database of health care information. Based on this factor, Ray Campbell of Massachusetts Health Data Consortium identified "a community and a cooperative dimension" to the collection of health data, which led him to then recommend additional investments in data and analytic infrastructure in state government. Commissioner Barbara Leadholm of the Department of Mental Health also suggested a state role in collecting health data, and Commissioner John Auerbach of the Department of Public Health suggested that analysis of data collected by DHCFP, such as hospital case mix data, could help support health resource planning.

To this end, DHCFP is developing an All Payer Claims Database (APCD), which will contain data for private claims including both self- and fully-insured groups, as well as data from Medicaid and Medicare. It is important that DHCFP be given the necessary legal and analytic tools in order to assure that the database is comprehensive and includes health care claims from both self and fully-insured groups in the state. The result will be one of the only all payer, all provider claims databases in the country and will represent unprecedented transparency through access to and analysis of health expenditures in Massachusetts.

DHCFP intends to make analytic datasets available to researchers and health care organizations in order to support their efforts to understand health care quality and cost, explore potential areas for policy improvements, and monitor system-wide trends. While many large purchasers and providers have limited in-house data for analysis of such issues, DHCFP's collection of data from all payers greatly improves the research process by making a broader and more representative set of data available. DHCFP's efforts to make these data public will also democratize this knowledge by making it accessible to a broader audience.

The APCD could be used to develop uniform price and quality performance measures and provider reporting tools to align providers and payers towards a common set of goals. Such a strategy would reduce the administrative complexity currently faced by many providers for whom performance is measured piecemeal for various subsets of their patient population, rather than for their practice as a whole.

Open and transparent price and quality information will be critical to the formation of a competitive marketplace and to transition towards an integrated delivery system. These data should serve as a "medical commons," a common resource to be used for the good of the community. DHCFP will facilitate its availability as well as provide strong data about the delivery system's capacity and resources in advance of the issues and opportunities that could potentially arise.

### 7. Government should support health system redesign through a variety of efforts

Although comprehensive system reform will require an ongoing cooperative partnership between the public sector and the health care industry, government interventions are necessary to guide and support the marketplace in finding equitable solutions to current imbalances.

a. *Guidance in developing actuarial tools for new shared-risk insurance products*
As alternative payment methodologies that hold providers accountable for a portion of their patient population's health expenditures become more prevalent, the conventional algorithms used by underwriters to calculate the necessary reserves that payers must have accessible are becoming outdated. Oral testimony offered by Ralph de la Torre of Steward Health Care System, and Andrei Soran of MetroWest Medical Center, suggests that the amount needed by insurers in reserves may be reduced as the health system shifts to alternate payment methods that transfer more risk to providers. Standardized methodologies for determining adequate levels of reserves may need to be developed as the healthcare landscape continues to change. The transition of the delivery system towards greater integration and shared risk will create new challenges as well as opportunities, and public agencies could provide much needed analytic support to health care underwriters. The Legislature should consider authorizing the Division of Insurance, in partnership with DHCFP, to establish new standards for determining the adequacy of payer reserves.

b. *Strengthening Health Resource Planning and Determination of Need Process*
The construction of unnecessary facilities and the proliferation of new, expensive technology can contribute to cost growth without necessarily improving health outcomes. Julie Pinkham of the Massachusetts Nurses Association testified to this point, while Public Health Commissioner John Auerbach described how his agency's resources for this process had been considerably diminished over the past several decades. Comprehensive, long-term resource planning and careful appraisal of existing and potential facilities and services will be critical to ensuring the successful implementation of health care reform in the Commonwealth. The Governor's health care bill calls for the establishment of a Division of Health Planning within the Department of Public Health, which would be responsible for developing a statewide health plan. The state health plan would include a complete inventory of all facilities, services, and technologies subject to Determination of Need. Based on the findings of the statewide health plan, the Division of Health Planning would issue regulations to improve and strengthen the Determination of Need process. Additional funding may be necessary to ensure adequate staffing and other resources at the Department of Public Health to support these activities.

c. *Potential standardization of base provider service rates*
The movement towards care integration and improved efficiency is promising, but some experts believe that government must be prepared to intervene further should the market fail to respond adequately to health care reform. The recently convened Special Commission on Provider Price Reform included in their recommendations that an independent panel, staffed by DHCFP, be given the authority to determine whether disputed price increases in payer-provider contracts are justified based on the demonstrated quality of the service. Another potential tool discussed during the Cost Trends public hearing is legislation authorizing a state entity to standardize a set of base rates for services to be used by providers and payers in rate negotiations. Rate adjustments for appropriate factors (such as teaching obligations, infrastructure agreements, risk-sharing arrangements, patient acuity, and quality of care) could be made according to a defined adjustment schedule; however, providers and payers would have substantially restricted capacity to negotiate for rates that differ substantially from the standardized base. In an approach advocated by Tufts Medical Center's Ellen Zane, and by Rhode Island Health Insurance Commissioner Christopher Koller, the government entity could publish these guidelines for rates while stopping short of explicit rate-setting. The Special Commission on Provider Price Reform is focused on providing specific recommendations to narrow provider price variation, and included in their recommendations a proposal for an independent body to be responsible for identifying the acceptable and unacceptable factors for price variation.

## 8. Invest in infrastructure improvements to promote an integrated health care system

Transitioning towards an integrated and efficient health care delivery system will require substantial investments in infrastructure. Three central areas for development are:

a. *Information technology*
The use of health information technology (HIT) has the potential to enhance coordination across providers, provide patients with electronic access to their own health information, and make information more readily available for supporting strategies to improve population health. The importance of HIT was a theme among provider representatives who testified at the public hearings. James W. Hunt, Jr. of the Massachusetts League of Community Health Centers, described his organization's success in improving care at seven pilot health centers using a web-based tool to extract data from electronic health records and create health center-specific quality reports and performance indicators. Provisions in state and federal law offer opportunities and guidelines for providers in utilizing electronic health records (EHRs) and developing interoperable networks. In particular, the American Reconciliation and Recovery Act (ARRA) of 2009 made substantial funding available to support the adoption of EHRs and to expand the capacity for system-wide health information exchange. DHCFP recommends that the Commonwealth continue to support current efforts to promote and expand the use of HIT and that both providers and payers continue to work together to create uniform standards for usage and interoperability of HIT across all provider types.

b. *Appropriate staff to use, evaluate, and create data*
Similar to HIT, the use of data as a tool to better understand quality of care and to improve coordination was also a theme during the public hearings. In order to increase their ability to manage risk, providers will need to increasingly collect and analyze data to inform the health care delivery process. In addition, greater provider integration through ICOs and alternative payment methods will bring the need for providers to share data. These types of changes require not only IT investments as described above, but also investments in staff who can create, evaluate, and utilize data analyses to improve practices. During the hearings, David Polakoff of MassHealth and the University of Massachusetts Medical School noted the need for providers to hire and train such staff. Several witnesses also indicated that the state government should take a more active role in collecting and disseminating data, suggesting a need for investments in government staff with these skill sets.

c. *Health care workforce development*
The public hearings produced consensus between many stakeholders and industry representatives that the capacity of the current health care workforce must be enhanced in order to meet the changing needs of the population in a reformed health care system. Health care professionals will likely have expanded roles in care management and wellness promotion, while greater efficiency may cause existing staffing levels to shift. As vital contributors to the Massachusetts economy, health care workers will need support from policy makers in order to develop new skills and improve care processes. An adequate supply of primary care providers will be essential to ensuring that residents of the Commonwealth have access to comprehensive and coordinated care. Long-term health care planning should be informed by considerations of the workforce necessary to accomplish the goals of health care reform, and how to capitalize on the strengths of health care professionals.

### 9. Invest in public health and wellness

The Commonwealth should continue to promote and invest resources in wellness through public-private partnerships that reduce the incidence and prevalence of common chronic conditions. Rising levels of preventable or manageable chronic diseases represent significant areas of opportunity for improved health outcomes, productivity, and cost savings associated with a reduction in avoidable hospitalizations or emergency department visits. As testified by Allison Bayer of Cambridge Health Alliance, "Many of the solutions to today's health challenges, including obesity, diabetes, and environmental triggers to asthma, represent a collaboration that bridges the traditional divide between public health and the health care delivery system." Employers in particular have leverage to engage employees and their families in wellness activities, and may be able to impact their health insurance premiums through such programs. However, direct savings are not likely to be realized in the short-term; continued resources in public health planning should be considered a necessary and responsible investment in the public good.

### 10. Develop and standardize measures of provider quality and health system performance

Commonly-used quality measures are not sensitive to differences in care between different providers. As health policy discussions at the state and national level have focused increasingly on quality measurement and improvement, health care providers have adapted to perform well against these measures, so that many providers receive high scores on these measures and there are few providers who perform differently than the average. Continued improvement in the health care system will require raising the bar by setting new goals. Existing quality measures focus on the performance of individual providers or the quality of care for individual visits. As health system redesign evolves to include ICOs and alternative payment methods, new quality measures should be tested, refined, and promoted in order to better understand quality across the continuum of patient care (from ambulatory to acute care settings) and across episodes of care.

State law already acknowledges the need for additional work on quality measurement. Pursuant to Section 54 of Chapter 288 of the Acts of 2010, DPH convened a committee to recommend a standard set of quality measures for health care facilities and provider groups in the Commonwealth. To develop these recommendations, the committee may consider existing use of quality measures by state and federal agencies, as well as input from health care providers regarding appropriate measures. Creation of a standard set of quality measures will further administrative simplification for health care providers who currently must adhere to different sets of measures used by different payers, in the form of pay-for-performance initiatives or provider categorization in tiered network plans. Providing direction on use of quality measures will allow the Commonwealth to set priorities and goals for health systems redesign. In addition to the requirements set out by Section 54, the selection of quality measures should take into account goals for care coordination and greater provider integration. Quality measures should be selected not only to provide information on the efficacy of individual providers, but also to measure and track the quality of the overall health system throughout continued health care reform efforts.


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